Physical Therapy

Which physicians are eligible to provide physical therapy?

[Refer to WAC 388-545-500(1)]

- Licensed physiatrists

Where must physical therapy services be provided?

[WAC 388-545-500(3)(a)(f)]

Physical therapy services that Medical Assistance Administration (MAA) eligible clients receive must be provided as part of an outpatient treatment program.

- In an office, home, or outpatient hospital setting;
- By a home health agency as described in Chapter 388-551 WAC;
- As part of the acute physical medicine and rehabilitation (Acute PM&R) program as described in Acute PM&R subchapter 388-550 WAC;
- By a neurodevelopmental center;
- By a school district or educational service district as part of an individual education or individualized family service plan as described in WAC 388-86-022; or
- For disabled children, age two and younger, in natural environments including the home and community settings in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

Referral and Documentation Process

Adults (Age 21 and older) [Refer to WAC 388-545-500(5)]

Providers must document in a client's medical file that physical therapy services provided to clients age 21 and older are medically necessary. Such documentation may include justification that physical therapy services:

- Prevent the need for hospitalization or nursing home care;
- Assist a client in becoming employable;
- Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or
- Are a part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

<u>Children (Age 20 and younger)</u> (Refer to WAC 388-86-027)

The EPSDT screening provider must:

- Determine if there is a medical need for physical therapy; and
- Document the medical need and the referral in the child's physical therapy file.

The physiatrist must:

- Keep referral information on file in the form of a prescription, notes from telephone calls, etc.;
- Contact the referring EPSDT screening provider for information concerning the need for physical therapy services; and
- Keep the referring and/or continuing care provider apprised of the assessment, prognosis, and progress of the child(ren) the provider has referred to them for services.

Coverage [WAC 388-545-500(4)]

MAA pays only for covered physical therapy services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- Medically necessary and ordered by a physician, PA, or an ARNP;
- Begun within 30 days of the date ordered;
- For conditions which are the result of injuries and/or medically recognized diseases and defects; and
- Within accepted physical therapy standards. [WAC 388-545-500(4)]

What is covered? [Refer to WAC 388-545-500(7-8)]

☞ **Note:** A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

- MAA does not limit covered physical therapy services if the client is 20 years of age or younger.
- MAA covers, without requiring prior authorization, the following ordered physical therapy services per client, per diagnosis, per calendar year for clients 21 years of age and older:
  - ✓ One physical therapy evaluation. The evaluation is in addition to the 48 program units allowed per year;
  - ✓ 48 physical therapy program units; and
  - ✓ 96 additional outpatient physical therapy program units for the diagnoses listed on the following page.
- MAA will pay for one visit to instruct in the application of transcutaneous electrical neurostimulator (TENS) per client, per lifetime.
- MAA covers two DME needs assessments per calendar year. Two physical therapy program units are allowed per assessment.
- MAA covers one wheelchair needs assessment in addition to the DME needs assessment per calendar year. Four physical therapy program units are allowed per assessment.

Additional Coverage (Client 21 years of age and older)

MAA covers a maximum of 96 physical therapy program units in addition to the original 48 units only when billed with one of the following diagnoses:

- **Principal** diagnosis codes:

Diagnosis Codes	**Condition**
315.3-315.9, 317-319	For medically necessary conditions for developmentally delayed clients
343 – 343.9	Cerebral palsy
741.9	Meningomyelocele
758.0	Down syndrome
781.2 – 781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800 – 829.1	Surgeries involving extremities – Fractures
851 – 854.1	Intracranial injuries
880 – 887.7	Surgeries involving extremities – Open wounds with tendon involvement
941 – 949.5	Burns
950 – 957.9, 959 – 959.9	Traumatic injuries

-OR-

- A completed/approved inpatient Acute Physical Medicine & Rehabilitation (Acute PM&R) when the client no longer needs nursing services but continues to require specialized outpatient therapy for:

854	Traumatic Brain Injury (TBI)
900.82, 344.0, 344.1	Spinal Cord Injury, (Paraplegia & Quadriplegia)
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss for, Multiple Sclerosis (MS)
335.20	Amyotrophic Lateral Sclerosis (ALS)
343 – 343.9	Cerebral Palsy (CP)
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)
941.4, 941.5, 942.4, 942.5, 943.4, 943.5, 944.4, 944.5, 945.4, 945.5, 946.4, 946.5	Extensive Severe Burns
707.0 & 344.0	Skin Flaps for Sacral Decubitus for Quads only
890 – 897.7, 887.6 – 887.7	Open wound of lower limb, Bilateral Limb Loss

Physical Therapy Program Limitations

Duplicate services for Occupational, Physical, and Speech therapy are not allowed for the same client when both providers are performing the same or similar procedure(s).
[WAC 338-545-500 (11)]

☞ **NOTE:** A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

If time is included in the CPT description, the beginning and ending times of each therapy modality must be documented in the client's medical record.

The following are considered part of the physical therapy program 48-unit limitation:

- Application of a modality to one or more areas not requiring direct patient contact (CPT codes 97010-97028);
- Application of a modality to one or more areas requiring direct patient contact (CPT codes 97032-97039);
- Therapeutic exercises (CPT codes 97110-97139);
- Manual therapy (CPT code 97140);
- Therapeutic procedures (CPT code 97150);
- Prosthetic training (CPT code 97520);
- Therapeutic activities (CPT code 97530);
- Self care/home management training (CPT code 97535);
- Community/work reintegration training (CPT code 97537); and
- Physical performance test or measurement (CPT code 97750). Do not use to bill for an evaluation (CPT code 97001) or re-evaluation (CPT code 97002).

The following are not included in the physical therapy program 48-unit limitation:

- Orthotics fitting and training upper and/or lower extremities (CPT code 97504). Two units are allowed per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Checkout for orthotic/prosethetic use (CPT code 97703). Two units are allowed per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Muscle testing (CPT codes 95831-95852). One muscle testing procedure is allowed per day. Muscle testing procedure s cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CPT codes.

- Evaluation of physical therapy (CPT code 97001). CPT code 97001 is for reporting the initial evaluation before the plan of care is established by the physical therapist or the physician. This evaluation is for evaluating the patient's condition and establishing the plan of care.

- Re-evaluation of physical therapy (CPT code 97002). Allowed once per calendar year, per client. CPT code 97002 is for reporting the re-evaluation of a patient who has been under a plan of care established by a physician or physical therapist. This evaluation is for re-evaluating the patient's condition and revising the plan of care under which the patient is being treated.

- Wheelchair needs assessments (CPT code 97703). One allowed per calendar year. Four physical therapy program units are allowed per assessment. Indicate on claim that this is a wheelchair needs assessment.

- DME needs assessments (CPT code 97703). Two allowed per calendar year. Two physical therapy program units are allowed per assessment. Indicate on claim the type of assessment.

- MAA reimburses Physical Therapists for active wound care management involving selective and non-selective debridement techniques to promote healing using CPT codes 97601 and 97602. The following conditions apply:

  - ✓ MAA allows one unit of CPT code 97601 or 97602 per client, per day. Providers may not bill CPT codes 97601 and 97602 in conjunction with each other.

  - ✓ Providers must not bill CPT codes 97601 and 97602 in addition to CPT codes 11040-11044.

- Custom splints (cockup and/or dynamic) (State-unique procedure code 0002M).

How do I request approval to exceed the limits?

For clients 21 years of age and older who need physical therapy in addition to that which is allowed by diagnosis, the provider must request MAA approval to exceed the limits. See Section I – Authorization.

Are school medical services covered?

MAA covers physical therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to MAA's School Medical Services Billing Instructions. (See Important Contacts.)

What is not covered? [WAC 388-545-500(12)]

- MAA does not reimburse separately for physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

Supplies

Office Supplies

- See Section K for supplies that can be billed individually.
- Procedure codes for supplies under $50.00 that do not have a fee listed will be reimbursed at acquisition cost; an invoice must be retained in the provider's file. An invoice must be submitted with the claim for supplies costing $50.00 or more.
- Effective with dates of service on and after July 1, 2002, HCPCS code A4550 (surgical tray) is bundled into the appropriate surgical procedures and the RVUs for these procedures have been adjusted accordingly. MAA will no longer reimburse providers separately for surgical trays.

Casting Materials

- Use state-unique codes 2978M through 2987M for fiberglass and plaster casting materials (see page K2). **Do not bill for the use of a cast room.** Use of a cast room is considered part of a provider's practice expense.

Catheter Supplies

- Separate payment is allowed for a temporary, indwelling catheter when it is used to treat a temporary obstruction and is performed in a physician's office. Use HCPCS procedure code G0002 to bill for this supply.
- MAA does not cover this procedure when it is performed on the same day as, or during the postoperative period of, a major surgical procedure.

Miscellaneous Services

DDD Physical: One physical (state-unique code 0310M) is allowed every 12 months.

AIDS Counseling: One precounseling and one postcounseling session (state-unique code 9020M) are allowed per client. [Refer to WAC 388-531-0600]

Detox: Three-day alcohol detox and/or five-day drug detox services (state-unique codes 0025M and 0026M) are provided only in a MAA-enrolled hospital based detoxification center. Use the appropriate ICD-9-CM diagnosis code and appropriate detox provider number.
[Refer to WAC 388-531-1650]

Note: Bill MAA directly for managed care clients.

Heart Catheterization: Use modifier 26 (professional component) when billing CPT codes 93501-93533, as heart catheterizations are reimbursed only if performed in a hospital setting, except in the case of special agreements.

Needle (Electromyography) EMGs: MAA has adopted CMS established limits for billing needle EMGs, CPT codes 95860 through 95870. The limits are as follows:

Code	Description	Limits
95860 95861 95863 95864	Needle EMG one extremity; With or without related paraspinal areas Two extremities with or without… Three extremities with or without… Four extremities with or without…	• For these to pay, extremity muscles innervated by three nerves or four spinal levels must be evaluated with a minimum of five muscles studied.
95869	Needle EMG; thoracic paraspinal muscles;	• May be billed alone ─ for thoracic spine studies only • Limited to one unit per day • For this to pay with extremity codes, test must be for T3-T11 areas only; if only T1 or T2 are studied, it is not payable separately.
95870	Needle EMG; other than paraspinal muscles (e.g., abdomen or thorax	• Limited to one unit per extremity *and* one unit for cervical or lumbar paraspinal muscles regardless of number of levels tested (five units maximum payable). • Not payable with extremity codes (CPT codes 95860-95864).

Medical justification to bill for the EMGs must be maintained in the client's file.

Cochlear Implant Services [Refer to WAC 388-531-0200(4)(c)]

MAA's policy regarding cochlear implant services is as follows:

- CPT code 69930, cochlear implants, requires prior authorization (refer to Section I – Authorization). Providers need to send in all medical information explaining why the client needs cochlear implants. In particular, MAA needs information on how the client was counseled on the different options for dealing with hearing loss such as, but not limited to, manual language.

- MAA reimburses physicians for replacement parts for cochlear implants given directly to the client using the HCPCS code A9900. Prior authorization is required for the replacement parts and will be manually price by the authorization department.

- The procedure can be performed in an inpatient hospital setting, outpatient hospital setting or in an Ambulatory Surgery Center (ASC).

- Hospitals must bill the appropriate DRG. The cochlear device and new or refurbished replacement parts are included in the DRG.

- Outpatient hospitals must bill revenue code 278 and attach an invoice for the cochlear device and new or refurbished replacement parts. Reimbursement is through ratio of costs to charges (RCC).

- Ambulatory Surgery Centers (ASCs) must use procedure code L8614 for the cochlear device. ASCs must use HCPCS code L8619 for new replacement parts, and HCPCS code A9900 only for refurbished replacement parts. Enter "refurbished speech processor" in field 19 on the HCFA-1500 claim form or in the Remarks/Comments field for direct entry, magnetic tape or EMC.

Acute Physical Medicine and Rehabilitation (PM&R)

- Inpatient physical medicine and rehabilitation (PM&R) is limited to MAA-contracted facilities. Call 1-800-634-1398.

Vagus Nerve Stimulation (VNS) [Refer to WAC 388-531-0200(h)]

MAA's policy regarding VNS is as follows:

- VNS CPT codes 61885, 61886, 61888, 64573, and 64585 require prior authorization (refer to Section I – Authorization).
- The procedure s can be performed in an inpatient hospital or outpatient hospital setting.
- Hospitals must bill the appropriate DRG. The VNS implant is included in the DRG.
- Outpatient hospitals must bill revenue code 278 and attach an invoice for the VNS implant. Reimbursement is through ratio of costs to charges (RCC).
- Prior authorization is **not required** for programming CPT codes 95970, 95974, and 95975 performed by the neurologist.

Osseointegrated Implants

Retroactive to dates of service on or after January 1, 2001:

- CPT codes 69714-69718 require prior authorization (refer to Section I – Authorizations).
- The procedure can be performed in an inpatient hospital setting or outpatient hospital setting.
- Hospitals must bill the appropriate DRG. The osseointegrated implant is included in the DRG.
- Outpatient hospitals must bill revenue code 278 and attach an invoice for the osseointegrated implant. Reimbursement is through a ratio of cost to charges (RCC).

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